BRIEF SUMMARY OF MEDICAL REIMBURSEMENT PROCESS

BE SURE TO READ THE "DETAILED" INSTRUCTIONS

1) Complete the ***REQUEST*** form (FOC 13) and attach all bills and/or statements that indicate "proof of payment" of each listing on this form.

2) Date and sign the ***REQUEST*** form and submit the form and all statements to the other parent.

3) After 35 days from date on ***REQUEST*** form, if you have not received payment from the other parent, you may now submit the paperwork to the Friend of the Court.

4) Complete the ***COMPLAINT*** form (FOC 13a). Sign and date this form (the date on the ***COMPLAINT*** form should be at least 35 days after the date on the ***REQUEST*** form.

5) You may now submit the ***REQUEST*** form with all bills and/or statements showing "proof of payment", and the ***COMPLAINT*** form to the Friend of the Court for processing.

BAY COUNTY FRIEND OF THE COURT

INSTRUCTIONS FOR HEALTH CARE EXPENSES REIMBURSEMENT

You have requested the assistance of the Friend of the Court (FOC) to collect **reimbursement** for health care expenses. The FOC cannot act as your attorney, but will try to assist you to resolve this matter **if you provide the necessary information in the proper manner,** as explained below:

IMPORTANT: Unless the non-custodial parent SIGNS AS GUARANTOR for health care costs, or in the absence of a Court Order stating otherwise, the FOC considers the custodial parent responsible to the health care provider for payment of all uninsured medical expenses. **It is recommended that the custodial parent make payment arrangements with the provider to prevent any unpaid accounts from going to collections.** You must also contact the other parent to try to collect your reimbursement first.

ALL BILLS SHOULD BE SUBMITTED IN THE PROPER FORMAT WITHIN SIX MONTHS FROM THE DATE OF PAYMENT. THE FOC WLL NOT ACCEPT BILLS THAT ARE MORE THAN ONE YEAR OLD.

IF YOUR CURRENT SUPPORT ORDER PROVIDES FOR AN ANNUAL ORDINARY MEDICAL EXPENSE, YOUR ANNUAL UNINSURED HEALTH CARE EXPENSES MUST EXCEED THIS AMOUNT ($345.00 PER YEAR PER CHILD for Orders effective 10/1/08 and later; Orders effective prior to 10/1/08 the Ordinary Medical is $289.00 PER YEAR, PER CHILD) BEFORE REQUESTING A REIMBURSEMENT.

IF THE REQUEST IS NOT SUBMITTED PROPERLY, IT WILL BE RETURNED TO YOU.

BEFORE WE MAY ASSIST YOU, YOU MUST:

1. a.) Complete the FOC 13 (REQUEST) form
   b.) Attach copies of **PAID** receipts indicating "**PROOF OF PAYMENT**"
   c.) Submit one copy of the FOC 13 with paid receipts to the other party

2. a.) If you **do not receive payment or reach an agreement with the other party** regarding reimbursement with 35 days from the day you submitted the Request form and paid receipts to the other party, you must submit to the Friend of the Court the following:

3. a.) A copy of the FOC 13 (Request) form with the paid receipts that were sent to the other party

   b.) A **completed** FOC 13a (Complaint) form

PLEASE NOTE: THE DATE ON YOUR "COMPLAINT" FOR M **MUST** BE AT LEAST **35 DAYS** FROM THE DATE ON YOUR "REQUEST" FORM. THIS WILL LET THE FOTC KNOW THAT YOU HAVE REQUESTED PAYMENT FROM THE OTHER PARTY FIRST.

We **will not enforce** uninsured health care expenses which result from a parent's choice not to use available health care insurance.

When we receive a copy of the FOC 13 (Request) with paid receipts/bills and the FOC 13a (Complaint) we will begin the collection process. We may schedule an office conference, file a Petition and Order to Show Cause or pursue modification of an Income Withholding Order in order to determine and/or collect the amount due.

The FOC will make every effort to see that each parent pays his or her fair share of these expenses; however, **your cooperation in providing the above-mentioned information is crucial.**

SAMPLE

Approved, SCAO

Original - Obligor
1st copy - Requesting party
2nd copy - for court as needed

STATE OF MICHIGAN 18th JUDICIAL CIRCUIT Bay COUNTY	REQUEST FOR HEALTH CARE EXPENSE PAYMENT	CASE NO. 4

Friend of the Court address
P.O. Box 831, Bay City, Michigan 48707-0831

Telephone no.
(989) 895-4295

Plaintiff: JANE DOE

v

Defendant: JOHN DOE

INSTRUCTIONS FOR REQUESTING PARTY:

The following is important information should you later seek to obtain the friend of the court's help to enforce payment of health care expenses (medical, dental, and other health care expenses).

1. Your court order must require the other party to pay a portion of health care expenses.
2. The expense must exceed any amounts your child support order requires as a prerequisite for enforcement.
3. You must submit your request for payment to the other party within 28 days of either the date insurance has paid on the expenses or the date insurance denies payment.
4. If you and the other party reach an agreement concerning the expenses, the agreement must be in writing, list the expenses to be paid, state the total amount to be paid, and provide a schedule for payment. Both parties must sign the agreement.
5. The bills must be presented to the friend of the court within the earliest of: 1 year after the expense was incurred; 6 months after the insurer's final denial of coverage for the expense (as long as all measures necessary to submit the claim to insurance were completed within 2 months after the expense was incurred); or 6 months after a default in a repayment agreement as set forth above. You will need to fill out a second form to request enforcement.
6. In the event it is necessary for the friend of the court to enforce payment of the expenses, you must have supporting bills and receipts for the expenses you list. You will be responsible for establishing the expenses and their necessity. Please bring your documentation to all court hearings where medical expenses may be discussed.
7. Attached a copy of all bills and insurance notifications to this form.
8. **You must keep a copy of this form and all attachments for the friend of the court to use in the event enforcement action is necessary.**

TO: Obligor's name and address
JOHN DOE
1234 ANY ST.
SOME CITY, MI 00000

this is the amount you paid

The following expenses have been incurred for the health care of a minor child for whom you are obligated to provide health care support.

Name of Child Receiving Service	Name of Medical Provider	Date of Service	Type of Service	Total Medical Cost	Amt. Paid by Insurance	Balance Due	Obligor's %	Amt. Owed by Obligor
SUSIE DOE	DR. SMITH	1/1/08	DENTAL	600.00	500.00	100.00	50%	50.00
SAM DOE	RITE AID	4/3/08	RX	50.00	45.00	5.00	50%	2.50
SUSIE DOE	DR JONES	7/10/08	check up	700.00	?	60.00	50%	30.00

I declare that the above statements are true to the best of my information, knowledge, and belief and that on this date I mailed a copy of this Request for Health Care Expense Payment to the obligor at his or her last known address.

X _____
Date

X _____
Signature

USE THIS PAGE FOR ADDITIONAL ENTRIES

SAMPLE

SUMMARY OF SUBMITTED MEDICAL EXPENSES (Cont.)

Name of Child	Name of Medical Provider	Date of Service	Type of Service	Total Medical Cost	Amt. Paid by Insurance	Balance Due	Obligor's %	Amt. Owed by Obligor
EXAMPLE								
*	If there is Ordinary Medical amount that needs to be split, calculate amount due from other parent as follows:							
	$1,500.00		parent expert in Ordinary Medical					
	-$345.00							
	$1,155.00							
	@ 60%		Other parents Court ordered %					
	$693.00		Amount other parent owes					

SAMPLE

Approved, SCAO | Original - Court; 1st copy - Obligor | 2nd copy - Requesting party; 3rd copy - FOC file

STATE OF MICHIGAN 18th JUDICIAL CIRCUIT Bay COUNTY	COMPLAINT FOR ENFORCMENT OF HEALTH CARE EXPENSE PAYMENT	CASE NO. *

Friend of the Court address: P.O. Box 831, Bay City, Michigan 48707-0831

Telephone no.: (989) 895-4295

Plaintiff: JANE DOE

v.

Defendant: JOHN DOE

TO:

Obligor's name and address:
JOHN DOE
1234 ANY ST
SOME CITY MI 00000

Notice to Obligor:
Under MCL 552.611a the friend of the court has been asked to enforce the health care expenses described below. Unless you file a written objection with the clerk of circuit court (including a copy for the friend of the court) within 21 days of the date provided in MCL 552.611, the expenses will be added to your support account as a health care support arrearage and enforced. If you timely file a written objection in the manner required, a hearing will be set to resolve the health care complaint.

I certify that on this date I mailed a copy of this complaint to the obligor by ordinary mail to the obligor's last known address.

Date _____ Friend of the court/Authorized representative _____

Requesting Party's Statement:

I request the friend of the court to enforce health care expenses. Attached is the request for Health Care Expense Payment (including all supporting documents) given to the obligor. **I declare that:**

1. I requested payment within 28 days of the date notified of the balance due after insurance payments.
2. This request is for expenses that are more than the minimum amount my order requires for enforcement.
3. * This complaint is
   - ☐ within 6 months after the date of the insurer's final denial of coverage for the expense.
   - ☐ within 1 year of the date the expense was incurred.
   - ☐ within 6 months after the obligor's default of an agreement to repay (copy of agreement attached).
4. * As of this date, the expense information in the attached Request for Health Care Expense Payment is true except as follows:

Since the date I mailed the Request for Health Care Expense Payment to the obligor, the obligor paid $_____

for _____ and _____.
Name(s) of child(ren) Name(s) of medical provider(s)

I declare that the above statements are true to the best of my information, knowledge, and belief.

* Date _____ * Signature _____

Approved, SCAO

Original - Obligor
1st copy - Requesting party
2nd copy - for court as needed

STATE OF MICHIGAN 18th JUDICIAL CIRCUIT Bay COUNTY	REQUEST FOR HEALTH CARE EXPENSE PAYMENT	CASE NO.

Friend of the Court address
P.O. Box 831, Bay City, Michigan 48707-0831

Telephone no.
(989) 895-4295

Plaintiff

v

Defendant

INSTRUCTIONS FOR REQUESTING PARTY:

The following is important information should you later seek to obtain the friend of the court's help to enforce payment of health care expenses (medical, dental, and other health care expenses).

1. Your court order must require the other party to pay a portion of health care expenses.
2. The expense must exceed any amounts your child support order requires as a prerequisite for enforcement.
3. You must submit your request for payment to the other party within 28 days of either the date insurance has paid on the expenses or the date insurance denies payment.
4. If you and the other party reach an agreement concerning the expenses, the agreement must be in writing, list the expenses to be paid, state the total amount to be paid, and provide a schedule for payment. Both parties must sign the agreement.
5. The bills must be presented to the friend of the court within the earliest of: 1 year after the expense was incurred; 6 months after the insurer's final denial of coverage for the expense (as long as all measures necessary to submit the claim to insurance were completed within 2 months after the expense was incurred); or 6 months after a default in a repayment agreement as set forth above. You will need to fill out a second form to request enforcement.
6. In the event it is necessary for the friend of the court to enforce payment of the expenses, you must have supporting bills and receipts for the expenses you list. You will be responsible for establishing the expenses and their necessity. Please bring your documentation to all court hearings where medical expenses may be discussed.
7. Attached a copy of all bills and insurance notifications to this form.
8. **You must keep a copy of this form and all attachments for the friend of the court to use in the event enforcement action is necessary.**

TO: Obligor's name and address

The following expenses have been incurred for the health care of a minor child for whom you are obligated to provide health care support.

Name of Child Receiving Service	Name of Medical Provider	Date of Service	Type of Service	Total Medical Cost	Amt. Paid by Insurance	Balance Due	Obligor's %	Amt. Owed by Obligor

I declare that the above statements are true to the best of my information, knowledge, and belief and that on this date I mailed a copy of this Request for Health Care Expense Payment to the obligor at his or her last known address.

Date

Signature

SUMMARY OF SUBMITTED MEDICAL EXPENSES (Cont.)

Name of Child	Name of Medical Provider	Date of Service	Type of Service	Total Medical Cost	Amt. Paid by Insurance	Balance Due	Obligor's %	Amt. Owed by Obligor

Approved, SCAO

Original - Court
1st copy - Obligor

2nd copy - Requesting party
3rd copy - FOC file

STATE OF MICHIGAN 18th JUDICIAL CIRCUIT Bay COUNTY	COMPLAINT FOR ENFORCMENT OF HEALTH CARE EXPENSE PAYMENT	CASE NO.

Friend of the Court address
P.O. Box 831, Bay City, Michigan 48707-0831

Telephone no.
(989) 895-4295

Plaintiff

v

Defendant

TO:

Obligor's name and address

Notice to Obligor:
Under MCL 552.611a the friend of the court has been asked to enforce the health care expenses described below. Unless you file a written objection with the clerk of circuit court (including a copy for the friend of the court) within 21 days of the date provided in MCL 552.611, the expenses will be added to your support account as a health care support arrearage and enforced. If you timely file a written objection in the manner required, a hearing will be set to resolve the health care complaint.

I certify that on this date I mailed a copy of this complaint to the obligor by ordinary mail to the obligor's last known address.

Date

Friend of the court/Authorized representative

Requesting Party's Statement:

I request the friend of the court to enforce health care expenses. Attached is the request for Health Care Expense Payment (including all supporting documents) given to the obligor. **I declare that:**

1. I requested payment within 28 days of the date notified of the balance due after insurance payments.
2. This request is for expenses that are more than the minimum amount my order requires for enforcement.
3. This complaint is
   - ☐ within 6 months after the date of the insurer's final denial of coverage for the expense.
   - ☐ within 1 year of the date the expense was incurred.
   - ☐ within 6 months after the obligor's default of an agreement to repay (copy of agreement attached).
4. As of this date, the expense information in the attached Request for Health Care Expense Payment is true except as follows:

   Since the date I mailed the Request for Health Care Expense Payment to the obligor, the obligor paid $_____

   for _____ and _____.
   Name(s) of child(ren) Name(s) of medical provider(s)

I declare that the above statements are true to the best of my information, knowledge, and belief.

Date

Signature